Patient Information

PATIENT NAME (First Name, Middle Initial, Last Name)	PRIMARY PHONE	SECONDARY PHONE
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M or F) [ ]M [ ]F	MARITAL STATUS [ ]Married [ ]Single [ ]Other
EMPLOYER NAME & ADDRESS	OCCUPATION	PATIENT ID (Office Use Only)

Responsible Party

RESPONSIBLE PARTY NAME (First Name, Middle Initial, Last Name)	HOME PHONE	WORK or OTHER PHONE
ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	SEX (M or F) [ ]M [ ]F	PATIENT'S RELATION TO RESP
EMPLOYER NAME & ADDRESS	OCCUPATION	RESP PARTY ID (Office Use Only)

Primary Insurance

Do you have a primary insurance carrier [ ] Yes [ ] No

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURED'S HOME PHONE	INSURED'S WORK PHONE
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION	
INSURANCE COMPANY NAME	INSURED'S ID #	
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #	
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT	

Secondary Insurance

Do you have a secondary insurance carrier [ ] Yes [ ] No

INSURED'S NAME (First Name, Middle Initial, Last Name)	INSURED'S HOME PHONE	INSURED'S WORK PHONE
INSURED'S ADDRESS	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NO.
INSURED'S CITY, STATE, ZIP	INSURED'S SEX (M or F)	INSURED'S RELATION TO PATIENT
INSURED'S EMPLOYER	INSURED'S OCCUPATION	
INSURANCE COMPANY NAME	INSURED'S ID #	
INSURANCE COMPANY ADDRESS	INSURED'S GROUP #	
INSURANCE COMPANY CITY, STATE, ZIP	INSURANCE COPAY AMOUNT Same as primary	

Authorization and Acknowledgement

I / We hereby state that the above information is true and correct to the best of my / our knowledge. I / We authorize the above named practice to release any information acquired in the course of my treatment to my insurance company, employer, Physicians, institutions or third party payors, as required for certain claims filed.

Signature of Patient / Parent / Guardian _____ Printed Name _____ Date _____

I / We authorize direct payment to be made to the above named practice for any and all medical or surgical services rendered. I understand if any services or charges are not covered by my insurance carrier or my eligibility can not be verified, I am responsible for all charges incurred.

Signature of Patient / Parent / Guardian / Insured _____ Printed Name _____ Date _____